**IN THE UNITED STATES PATENT AND TRADEMARK OFFICE**

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| In re Patent Application of: Terrance Moore | ) | Confirmation No.: 9723 |
| Serial No.: 09/812,703 | ) | Examiner: Vanel Frenel |
| Filed: 03/19/2001 | ) | Group Art Unit: 3627 |
| For: METHOD FOR COLLECTING FEES FOR HEALTHCARE MANAGEMENT GROUP | ) | Attorney Docket No. 044258.000002 |

**PETITION TO WITHDRAW APPLICATION FROM ISSUE UNDER 37 C.F.R. 1.313**

Mail Stop: Petitions - Fee
Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

Sir:

Petitioner respectfully requests that the Office withdraw from issuance Patent Application Serial No.: 09/812,703 under 37 CFR § 1.313(c)(2) in consideration of a Request for Continued Examination (RCE) ("Exhibit A") filed herewith under separate cover, submitted so that information provided in an accompanying Information Disclosure Statement (Exhibit B) cited in a related application can be considered. The issue fee for the subject Application was paid on September 27, 2007.

The Commissioner is hereby authorized to charge the petition fee set forth in §1.17(h) in the amount of $130 or any additional fees which may be required to Bracewell & Giuliani, L.L.P.'s Deposit Account No. 50-0259 (Attorney Docket No.: 044258.000002).

Respectfully submitted,

Date: 03/14/2006

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PTO/SB/30 (09-03)
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# Request for Continued Examination (RCE) Transmittal

Address to:
Mail Stop RCE
Commissioner for Patents
PO Box 1450
Alexandria, VA 22313-1450

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| *Application Number* | 09/812,703 |
| *Filing Date* | 03/19/2001 |
| *First Named Inventor* | Terrance Moore |
| *Art Unit* | 3627 |
| *Examiner Name* | Vanel Frenel |
| *Attorney Docket Number* | 044258.000002 |

**This is a Request for Continued Examination (RCE) under 37 CFR 1.114 of the above-identified application.** Request for Continued Examination (RCE) practice under 37 CFR 1.114 does not apply to any utility or plant application filed prior to June 8, 1995, or to any design application. See Instruction Sheet for RCEs (not to be submitted to the USPTO) on page 2.

1. Submission required under 37 CFR 1.114 – Note: If the RCE Is proper, any previously filed unentered amendment and amendments enclosed with the RCE will be entered in the order in which they were filed unless applicant instructs otherwise. If applicant does not wish to have any previously filed unentered amendment(s) entered, applicant must request non-entry of such amendment(s)
   - a. ☐ Previously submitted. If a final Office Action is outstanding, any amendments filed after the final Office Action may be considered as a submission even if this box is not checked.
     - i. ☐ Consider the arguments in the Appeal Brief or Rely Brief previously filed on _____
     - ii. ☐ Other:
   - b. ☒ Enclosed
     - i. ☐ Amendment/Reply
     - ii. ☐ Affidavit
     - iii. ☒ Information Disclosure Statement (IDS)
     - iv. ☐ Other:
2. Miscellaneous
   - a. ☐ Suspension of action on the above-identified application is requested under 37 CFR 1.103(c) for a period of _____ months. (Period of suspension shall not exceed 3 months; fee under 37 CFR 1.17(i) required)
   - b. ☐ Other
3. Fees The RCE Fee under 37 CFR 1.17(e) is required by 37 CFR 1.114 when the RCE is filed.
   - a. ☒ The Director is hereby authorized to charge the following fees, or credit any overpayments, to Deposit Account No. 50-0259
     - i. ☒ RCE fee required under 37 CFR 1.17(e)
     - ii. ☐ Extension of time fee (37 CFR 1.136 and 1.17)
     - iii. ☐ Other : _____
   - b. ☐ Check in the amount of $ _____ enclosed
   - c. ☐ Payment by credit card (Form PTO-2038 enclosed)

**WARNING: Information on this form may become public. Credit Card information should not be included on this form. Provide credit card information and authorization on PTO-2038.**

| *SIGNATURE OF APPLICANT, ATTORNEY, OR AGENT REQUIRED* | | | |
|---|---|---|---|
| Name (Print/Type) | DenverBisignano | Registration No. (Attorney/Agent) | 60,693 |
| Signature | | Date | 03-14-2006 |

| *CERTIFICATE OF MAILING OR TRANSMISSION* | | | |
|---|---|---|---|
| I hereby certify that this correspondence is being deposited with the United States Postal Service with sufficient postage as **first class** mail in an envelope addressed to: Mail Stop RCE, Commissioner for Patents, P. 0. Box 1450, Alexandria, VA 22313-1450. | | | |
| Name (Print/Type) | | | |
| Signature | | Date | |

This collection of information is required by 37 CFR 1.114. The information is required to obtain or retain a benefit by the public which is to file (and by the USPTO to process) an application. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.14. This collection is estimated to take 12 minutes to complete, including gathering, preparing, and submitting the completed application form to the USPTO. Time will vary depending upon the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden, should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, P.O. Box 1450, Alexandria, VA 22313-1450, DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. **SEND TO: Mail Stop RCE, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 2231 3-1450.**

*If you need assistance in completing the form, call 1-800-P TO -9199 and select option 2.*

**IN THE UNITED STATES PATENT AND TRADEMARK OFFICE**

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| In Re Patent Application of: Terrance Moore | ) | Confirmation No.: 9723 |
| Filed: 03/19/2001 | ) | Examiner: FRENEL, VANEL |
| Serial No. 09/812,703 | ) | Group Art Unit: 3687 |
| For: METHOD FOR COLLECTING FEES FOR HEALTHCARE MANAGEMENT GROUP | ) | Attorney Docket No. 044258.000002 |

**SUPPLEMENTAL INFORMATION DISCLOSURE STATEMENT UNDER 37 C.F.R. § 1.97 AND 1.98**

Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

Sir:

In compliance with the duty of disclosure under 37 C.F.R. §1.56, it is respectfully requested that this Information Disclosure Statement be entered and the references listed on attached Form PTO-1449 be considered by the Examiner and made of record.

Applicants submit herewith U.S. Patent Nos. 5,924,073, 6,381,576, as well as, non-patent literature documents entitled: "New Compensation Model Improves Physician Productivity" and "Creating a Bench Mark Database," cited in sister Application Serial No. 09/812,704. We believe these references to be less relevant and cumulative of those already of record. We nevertheless request the references be considered.

This Information Disclosure Statement is being filed along with a Request for Continued Examination. The Commissioner is hereby authorized to charge any fees, which may be required, now or in the future, to the undersigned's Deposit Account No. 50-0259 (Attorney Docket No. 044258.003).

Respectfully submitted,

Date: 03/14/2008

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Doc code :IDS
Doc description: Information Disclosure Statement (IDS) Filed

PTO/SB/08a (03-08)
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# INFORMATION DISCLOSURE STATEMENT BY APPLICANT

**( Not for submission under 37 CFR 1.99)**

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|---|---|
| Application Number | 09812703 |
| Filing Date | 2001-03-19 |
| First Named Inventor | Terrance Moore |
| Art Unit | 3627 |
| Examiner Name | Vanel Frenel |
| Attorney Docket Number | 044258.000002 |

**U.S.PATENTS**

| Examiner Initial* | Cite No | Patent Number | Kind Code[1] | Issue Date | Name of Patentee or Applicant of cited Document | Pages,Columns,Lines where Relevant Passages or Relevant Figures Appear |
|---|---|---|---|---|---|---|
| | 1 | 5924073 | | | | |
| | 2 | 6381576 | | | | |

If you wish to add additional U.S. Patent citation information please click the Add button.

**U.S.PATENT APPLICATION PUBLICATIONS**

| Examiner Initial* | Cite No | Publication Number | Kind Code[1] | Publication Date | Name of Patentee or Applicant of cited Document | Pages,Columns,Lines where Relevant Passages or Relevant Figures Appear |
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| | 1 | | | | | |

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**FOREIGN PATENT DOCUMENTS**

| Examiner Initial* | Cite No | Foreign Document Number[3] | Country Code[2] i | Kind Code[4] | Publication Date | Name of Patentee or Applicant of cited Document | Pages,Columns,Lines where Relevant Passages or Relevant Figures Appear | T[5] |
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| | 1 | | | | | | | ☐ |

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**NON-PATENT LITERATURE DOCUMENTS**

# INFORMATION DISCLOSURE STATEMENT BY APPLICANT

**( Not for submission under 37 CFR 1.99)**

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|---|---|
| Application Number | 09812703 |
| Filing Date | 2001-03-19 |
| First Named Inventor | Terrance Moore |
| Art Unit | 3627 |
| Examiner Name | Vanel Frenel |
| Attorney Docket Number | 044258.000002 |

| Examiner Initials* | Cite No | Include name of the author (in CAPITAL LETTERS), title of the article (when appropriate), title of the item (book, magazine, journal, serial, symposium, catalog, etc), date, pages(s), volume-issue number(s), publisher, city and/or country where published. | T[5] |
|---|---|---|---|
| | 1 | DAVIS et al., New Compensation Model Improves Physician Productivity, July 1999, Healthcare Financial Management, Pgs. 46-49 | ☐ |
| | 2 | SCHWARTZ, Creating Benchmark Database, January 1998, Health Management Technology, Pgs. 65-66 | ☐ |

If you wish to add additional non-patent literature document citation information please click the Add button

**EXAMINER SIGNATURE**

| Examiner Signature | | Date Considered | |
|---|---|---|---|

*EXAMINER: Initial if reference considered, whether or not citation is in conformance with MPEP 609. Draw line through a citation if not in conformance and not considered. Include copy of this form with next communication to applicant.

[1] See Kind Codes of USPTO Patent Documents at www.USPTO.GOV or MPEP 901.04. [2] Enter office that issued the document, by the two-letter code (WIPO Standard ST.3). [3] For Japanese patent documents, the indication of the year of the reign of the Emperor must precede the serial number of the patent document. [4] Kind of document by the appropriate symbols as indicated on the document under WIPO Standard ST.16 if possible. [5] Applicant is to place a check mark here if English language translation is attached.

**New compensation model improves physician productivity**

Alexsandra Davis

An Ohio system incentive plan rewards physicians for achieving high-quality care, improved productivity, and operations efficiency.

In the mid-1990s, Meridia Health System, a hospital systems in the Cleveland, Ohio, area began acquiring primary care physician practices to form the core of an integrated delivery system to compete with other providers in the area. Unfortunately, the structure of the physician compensation plan for Meridia's new physician employees caused productivity to decline and losses to mount. Meridia appointed a task force that included physicians to develop a new compensation plan that bases pay on the application of a collection rate percentage to each physician's gross fee-for-service billings. While not perfect, the new compensation plan is helping both Meridia and its physicians achieve their mutual goals of high-quality care, reasonable productivity, and operating efficiency.

Hospitals and health systems that have attempted to protect and expand their patient bases by buying physician practices are finding that high overhead costs and declines in physician productivity are making this strategy unprofitable. Numerous surveys have found that hospitals have been incurring annual losses of as much as $100,000 per acquired physician.

Healthcare organizations that are trying to increase the productivity of their employed physicians often find that the physicians lack sufficient financial incentives and managerial skills to meet desired productivity levels. One health system in the Cleveland, Ohio, area, however, has rejuvenated the performance of its physician network by overhauling its physician compensation program and introducing effective incentives.

Forming a Primary Care Network

Since its formation through the merger of four independent hospitals in the 1980s, Meridia Health System has enjoyed a strong market position in Cleveland's eastern suburbs. Competition in the Cleveland healthcare market, however, has gradually intensified as a result of hospital consolidations, the acquisition of independent hospitals by for-profit hospital systems, and the development of integrated delivery systems (IDSs) that incorporate health plans, physician practices, and ancillary services into hospital-owned networks.

In 1992, Meridia decided that to remain competitive it had to develop a primary care physician network to form the core of an IDS. By 1995, through practice acquisitions and expansions, Meridia was operating four primary care practices employing a total of about 40 primary care physicians. An independent company was engaged to provide billing and management services for the network.

All physicians received two- or three-year guaranteed salary and benefit packages. Salaries were based on a review of each physician's existing salary level and years of experience, as well as industry compensation surveys. Benefit packages mirrored those of Meridia's senior executives, though some were modified to fit individual circumstances. Bonuses were available for physicians who met productivity targets. Most of these targets were based on a combination of the historical production level of each individual physician and industry averages.

Disappointing Network Results

Meridia executives had assumed that their physician practices would continue to function as they had before they were acquired. This assumption proved faulty for several reasons.

First, physician productivity declined for a variety of reasons. For example, many physicians spent less time in the office, saw fewer patients, and provided fewer services than they had before their practices were acquired.

Second, the transition to using contracted billing and management services caused disruptions to routine practice operations. These disruptions were compounded by the contracted company's failure to perform collection services adequately or develop management reports and distribute them in a timely fashion.

Third, new physicians recruited into the groups placed increased demands on practice resources and absorbed existing and new patient volume. The latter occurrence limited the opportunities of established physicians within the practices to maintain current productivity levels, let alone increase them.

Fourth, as practice sites were expanded or consolidated into new facilities, practice operations were disrupted. Patient volumes dropped in part due to practice location changes.

Losses from primary care network operations were in excess of $100,000 per physician, per year. In response, Meridia placed a moratorium on physician recruitment and practice acquisitions. A practice management and billing system was acquired and implemented internally. In addition, the practice administrative staff was restructured and augmented, with the hospital system's human resources and accounting departments assuming expanded responsibilities for network operations.

Revamping the Compensation Plan

A prime target of Meridia's loss-reduction effort was physician compensation. The system established a budget-reduction target for physician compensation of approximately $500,000, roughly 14 percent of current compensation levels.

Accordingly, a new compensation plan was proposed. Each physician was guaranteed a salary, of 50 percent of the industry compensation standard, as determined by examining surveys of the Medical Group Management Association, the Society of Medical and Dental Consultants, and the American Group Management Association, with the opportunity to earn up to 100 percent of the standard, depending upon the practice's achieving collection levels equal to the industry collection standard. Financial projections predicted that 36 percent of the physicians would earn higher salaries under the proposed plan, while 64 percent would earn an average of $20,000 per year less than their current compensation.

The plan seemed good in theory because it was based on industry standards and offered significant incentives to improve performance. After several meetings with the physicians, however, it was clear that the plan never would be implemented. Physicians felt it was imperative that they have a say in developing the physician compensation model, and they would not accept a plan that was mandated by administration.

Meridia therefore pursued a different direction. The system began by formally establishing a physician compensation task force composed of all its physician group presidents, additional physician representatives, and representatives from Meridia's practice management, human resource, and finance and accounting departments. A two-to-three-month time frame for development of a compensation plan was established.

The task force addressed the following issues:

* Assessment of current Meridia practice management services;

* Assessment of physician practice activities and results;

* Development of conceptual goals for physician compensation strategies;

* Identification of key problems associated with incentive-based compensation models and methods to resolve them;

* Identification of alternative compensation models;

* Selection of a compensation model; and

* Introduction of the model to physicians and implementation of the plan.

Early in the process, gross billings by physicians were chosen as a measure of physician activity After the gross billing was compared with industry standards, it became apparent that physician productivity was not as low as had been indicated by Meridia's earlier assessment of collections. Although some physicians still were "overpaid" relative to industry standards, the percentage of physicians with pay significantly over industry averages was not nearly as dramatic as the earlier projection of 64 percent.

Based in part on these findings, the task force developed the following goals for the compensation plan:

* The plan should provide reasonable and fair compensation to all physicians based on practice activities and results that physicians can control. This goal required the physicians to concede that compensation would vary from physician to physician and that receipt of historical compensation levels could not be guaranteed. Similarly, Meridia-controlled factors, such as billing and collection systems and payer mix at practice locations, would not impact physician salary negatively.

* The compensation plan should be flexible enough to accommodate unique aspects of each group and the market's transition to capitation.

* The plan should include different incentives to compensate physicians on their individual performance, their group's results, and the results of the network as a whole. These multilevel incentives were needed to demonstrate to the physicians that, as employees, they are accountable not only for their individual activities but also for the effect of those activities on group and network results.

* The new compensation plan should be phased in. A phased approach would ensure that the system would be able to provide information on practice performance to the physicians in a timely fashion, that physicians would understand the impact of their performance on their new compensation, and that physicians could effect changes in practice activities to achieve their compensation goals.

The New Compensation Plan

Physicians receive a one-to-two-year salary guarantee at time of employment. Then the compensation plan developed based on the task force's identified objectives comes into force.

Due to physician and administration skepticism regarding historical collection results obtained through the contracted billing and management company and the limited experience with the new in-house billing system, a collection rate of 68 percent (calculated collections) was selected arbitrarily to be applied to physician gross fee-for-service billings. (Other practice revenues, such as capitation and administrative stipends, were considered 100 percent collectible.) Physician salaries are based

on the application of a practice overhead rate (representing practice expenses and physician benefit costs) of 58 percent to calculated collections up to $275,000 and 50 percent to collections over this amount. This straightforward approach to compensation incentives addresses the highest priorities for the network: boosting productivity and improving operating efficiency.

To determine physician compensation, the network reviews each physician's productivity during the most current 12-month period and determines the calculated collections he or she generated. This amount then is multiplied by the applicable overhead rate, and the balance remaining after deducting overhead from the collections figures represents the physician's total budgeted salary.

The physician then is paid 100 percent of that amount for the next six months. If, at the end of six months, the physician falls below his or her targeted productivity level, the physician's salary is adjusted downward to a maximum 35 percent reduction. If the physician's productivity level is above the target, he or she receives a bonus based on the appropriate 58 percent and 50 percent overhead rates previously mentioned. This amount is paid immediately or put into escrow, if the physician wishes, to use to supplement his or her income should the physician's earnings decrease in the future.

Following approval of the plan, all physicians began to receive monthly reports that showed their current production and what their compensation would be under the new plan compared with their current salary. The group presidents were responsible for helping the physicians interpret the results and develop strategies to achieve their compensation goals. Administration committed to providing accurate reports of practice results within three working days of the end of the month.

A standing committee was established to monitor the compensation plan results and to monitor and modify the practice activities to ensure that the incentives of the compensation plan were producing the desired results.

Results and Conclusion

Results of the new compensation plan have been positive. In the first year, 25 physicians were compensated under the new plan: 13 of these physicians exceeded the budget target for their practices, generating $400,000 over budget in revenues. Increases in practice productivity ranged from 10 to 25 percent. Patient encounters also increased by 6,000 visits among the 25 physicians on the plan.

Actual network overhead costs are shrinking, and the relationship between the physicians and administration has improved. Physician participation in educational programs on topics such as billing, coding, chart documentation, clinical protocols, and utilization management has improved, and most importantly, practice patterns are changing.

One group has already modified the compensation plan by withholding 10 percent of the budgeted compensation and distributing the withheld amount to its physicians based on the results of patient satisfaction surveys. Financial results compared with budget for each group are being monitored and will be introduced as an incentive component of the plan next year. Additional elements of practice activities and results, including RVU output per physician and patient-severity weighting, are being tracked and reported for potential future incentive applications.

The transition has not been without turmoil. Several physicians have left the network, and a number of others have seen their pay reduced and have received intensive counseling on their professional practices. Nonetheless, a general consensus among physicians has been reached regarding the long-term benefits of the new compensation plan and the need for teamwork. The physician group presidents have begun to exert leadership through this process and are now an integral component of Meridia's management team.

Meridia Health System recognizes that its compensation plan is a work in progress. It is important for hospitals and health systems to be realistic about what a compensation plan can and should accomplish and test the incentive compensation models to ensure they produce the desired outcomes. To effectively modify behavior, physicians need to receive consistent reports and feedback.

Any physician compensation plan must have physician buy-in to work. Physicians understandably will not react well to a mandate from administration regarding the sensitive issue of compensation. Therefore, the best way. to achieve this buy-in is to involve physicians in developing the plan right from the start and patiently, effectively facilitate their participation.

Meridia's compensation plan is not perfectly fair - no compensation plan ever will be. However, through good-faith negotiations and compromise, Meridia and its primary care physicians were able to develop a workable compensation system that is helping both parties achieve their mutual goals of high-quality care, appropriate productivity, and operating efficiency.

ABOUT THE AUTHORS

Alexsandra Davis, MPA, is vice president of business development, Physician Business Systems, Independence, Ohio.

C. Thompson Hardy, MHA, FACMPE, is director, New Health Management, Inc., Cleveland, Ohio.

**Creating a benchmark database - Viewpoint - Technology Information - Column**

David Schwartz

Information has become the most powerful weapon in the arsenal of health care organizations as they fight to win managed care contracts, then manage those contracts profitably.

Many organizations are making huge investments in information technology as this war gets more and more competitive, and IT professionals like you have become the leaders of the battle, mapping out strategies to conquer the complex maze of internal data sources and systems, then linking them together like battalions of soldiers. marching in sync with coordinated power.

But what many organizations fail to see in this quest is the importance of external data to compare your performance with, and to use as a guidepost for decision making. IS professionals can give their organizations an important advantage in terms of negotiating and decision-making savvy by creating a benchmark database, then linking it with internal performance data.

Such a benchmark database has several critically important, strategic uses, including the following:

* The benchmark data can be used to spur higher levels of performance among providers, departments or facilities that fall below benchmark rates;

* The external data can be used to help make assumptions about utilization, costs, and pricing when modeling rates for managed care contracting purposes;

* It can be used as basic intelligence on rates other providers are bidding and contracting for; and,

* It can be used to provide a "sniff test" when evaluating contract proposals.

What to benchmark?

The potential for specific benchmarks in a large health care organization are innumerable, but here's a list of the major categories to get you started, along with some typical benchmarks within those categories.

* Clinical benchmarks. Clinical benchmarking is used to urge providers on to higher levels of performance, to change and standardize practice patterns, and to reduce overutilization of high-cost care, ancillaries, and tests. Procedure- or disease-specific outcomes, complication rates, readmission rates, referral rates, and length of stay by diagnosis or procedure are just a few examples.

* Community health benchmarks. These can include measurements of health indicators in the local area versus national or regional norms, or measurement of your organization's performance in specific prevention and wellness initiatives. Examples of community health indicators include prevalence of overweight, smoking, seat belt use, asthma, diabetes, etc. Specific prevention and wellness benchmarks include mammography rate, immunization and vaccination rates, and rate of prostate cancer screening.

* Operations performance benchmarks. These benchmarks are generally used to evaluate the quality and efficiency of "back

office" functions within the organization, but this category might also include satisfaction rates in various clinical and operations areas. Specific examples might include average days in accounts receivable, average emergency department waiting times, average days to turn around claims and referral requests, and complaint rates per 1,000.

* Cost and efficiency benchmarks. In addition to the obvious cost benchmarks on a per procedure, per admission, per diem, per diagnosis, or per member basis, this category includes critical benchmarks such as admits per 1,000, referral rates, length of stay, bed days per 1,000, per member per month costs, and drug and ancillary costs by diagnosis, admit, procedure, and physician.

* Contracting benchmarks. When it comes to managed care contracting, having benchmarks to compare with contract proposals or assumptions underlying a proposed rate is vitally important. Specific benchmarks in this area start with actual or average PMPM rates and can include any or all of the data elements used to build a PMPM rate -- utilization data, severity scores, cost data, procedure frequency data, population/demographic data. It can also incorporate historical fee-for-service or discounted fee-for-service rates or other fee schedules as appropriate.

Where do benchmarks come from?

To build a benchmark database, you'll need a good nose for sniffing out sources of data, and a plan for cataloguing and storing the data for ease of retrieval and with an eye toward integrating the external benchmarks with internal data systems, allowing for easy comparisons.

Some organizations build consortiums or cooperative relationships with competing or similar organizations for the sole purpose of building a database of benchmark data -- which is certainly an excellent strategy if you can pull it off.

More commonly, benchmarks are purchased from consultants -- and publishers or found in journals, newsletters and other periodicals.

Our company, National Health Information, publishes an annual capitation survey and several books that many organizations use for benchmarking purposes, and we also publish two newsletters specifically devoted to benchmarking titled Capitation Rates & Data and Data Strategies & Benchmarks, respectively.

Excellent data is available from many consulting and actuarial companies, such as Milliman & Robertson, Delloite & Touche, The Camden Croup, and Tillinghast. Professional associations and specialty societies are also good sources of data, as are federal and state health agencies.

Here are a few specific sources on our "must have" list on addition to our own, of course):

* Medical Group Management Association, Englewood, Colo. (A treasure-trove of group practice performance, cost, and payment data.)

* The Center for Healthcare Industry Performance Studies (CHIPS), Columbus, Ohio.

* American Hospital Association and American Medical Association, both in Chicago, and both with some great statistical databases.

* Interstudy, St. Paul, Minn. (Very fine data on the HMO industry.)

* SMG Marketing Group, Chicago, which provides fabulous data that makes up the "Managed Care Digest" series of reports produced for Hoechst Marion Roussel.

Putting it all together

Many health care providers have benchmarks in various shapes, forms, and sizes, generally spread throughout the organization without an structured IT strategy for collecting cataloguing, and using the data for more effective, enterprisewide decision making.

Building a benchmark database is a project in need of a champion -- and who better than you?

The payoff? Three cheers for you and a major enhancement in your organization's ability to gauge and improve clinical and operational performance, bolster community health initiatives, enhance efficiency, assess contract proposals, and ultimately land more contracts and manage them more profitably.

David Schwartz is the president and publisher of National Health Information, L.L.C., Marietta, Ca. His e-mail is: nhinfo@aol.com.